D·U·L·U·T·H

CITY OF DULUTH
REQUEST FOR UNPAID FAMILY LEAVE OF ABSENCE

(Please Print or Type)

Employee Name: _____ **Date of Request:**_____

Department/Division: _____

Position Title: _____

SECTION A (To be completed by Employee)

1. I hereby request a family leave of absence for the following purpose:

___ Birth of child and to care for such child, or placement of child for adoption or foster care; expected date of birth or placement is _____.

___ To care for immediate family member with a serious health condition (must submit "Physician or Practitioner Certification"); check appropriate family member below:

___ Child ___ Spouse ___ Parent

___ My own serious health condition which renders me unable to perform my job (must submit "Fitness for Duty Report")

2. I am requesting: ___ Consecutive Leave ___ Intermittent or Reduced Leave Schedule (Specify schedule in space below):

_____

_____

_____

_____

3. Dates of requested *unpaid* leave: First Date of Leave: _____ Last Date of Leave:_____

4. Is this unpaid leave following any paid leave for the same qualifying event? ___Yes ___No

If yes, enter dates of paid leave: First Date of Leave: _____ Last Date of Leave:_____

-OVER-

3. If your leave (both paid and unpaid combined) will exceed 12 weeks, check one of the statements below (reinstatement following leaves of more than 12 weeks total is not guaranteed, but subject to approval):

___ I request reinstatement to my former position upon expiration of this leave.

___ I request placement on the re-employment list for my class upon expiration of this leave.

I understand that I must first use all accrued paid leave until exhausted, making up the balance of the requested leave with unpaid leave. I also understand that if my leave (paid and unpaid combined) exceeds 12 weeks, and that more than 30 days of the leave is unpaid, I must schedule an appointment with the Employee Benefits Administrator in Human Resources to arrange for continuation or cancellation of my benefits during the leave. I further understand that if my leave does not exceed 12 weeks, I will be returned to my same or similar position. If my leave should exceed 12 weeks, I will be returned to my same or similar position, only if approved or if available, in accordance with applicable laws. If my same or similar position is not available, I understand that I may be terminated or placed on a re-employment list for one year.

Employee Signature: _____ Date: _____

SECTION B -APPROVALS

NOTE: Requests that meet the FMLA criteria cannot be denied if employee is eligible for such leave (a maximum of 12 weeks leave is allowed in a 12-month period; see Policy CP-A 150).

_____ Date: _____
Supervisor Signature

_____ Date: _____
Department Director Signature

Manager, Human Resources (Required for all requests of 30 days or more) (Check one):

___ Request approved with reinstatement to former or similar position upon expiration of leave

___ Request approved with placement of name on re-employment list for the classification of _____. (Placement to occur on the first day following expiration of the leave of absence. Name will remain on re-employment list for one year, unless the period is extended by the Civil Service Board, in accordance with Civil Service Rule 13-26).

___ Request approved for 12 weeks only; leave will expire on _____ and employee will be reinstated to former or similar position upon expiration of leave.

_____ _____
Manager, Human Resources Date

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ORIGINAL TO: Human Resources/Personnel File
SIGNED COPIES (UNPAID LEAVE) TO: Employee; Immediate Supervisor; Employee Benefits Administrator; Payroll